

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/10/2013
NAME OF PROVIDER OR SUPPLIER WESTVIEW HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 3630 GUION RD INDIANAPOLIS, IN 46222		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of a State complaint.</p> <p>Complaint: IN00120800 Unsubstantiated, lack of sufficient evidence.</p> <p>Date of Survey: 01-02 & 03-13 & 01-10-13</p> <p>Facility number: 005110</p> <p>Surveyor: John Lee, R.N. Public Health Nurse Surveyor</p> <p>Westview Hospital is in compliance with 410 IAC 15-1.5-5, Medical staff, and 410 IAC 15-1.5-6, Nursing services, Hospital Licensure Rules.</p> <p>QA: cloughlin 01/17/13</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1